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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

CARLOS T. COOPER, JR., D.P.M. and
E. JOSEPH DANIELS, D.P.M.,
Petitioners,

v.

FORSYTH COUNTY HOSPITAL AUTHORITY, INC., *et al.*,
Respondents.

PETITIONERS BRIEF IN REPLY TO BRIEF FOR THE RESPONDENTS IN OPPOSITION TO CERTIORARI

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PETITIONERS BRIEF IN REPLY TO BRIEF FOR THE RESPONDENTS IN OPPOSITION TO CERTIORARI

Petitioners submit this brief in reply to the respondents' brief in opposition to *certiorari* ("Opp. Cert."). Curiously, while defending summary judgment granted to them, respondents raise a variety of factual disputes.[1] They fail, however, to minimize the national importance of the hospital access antitrust issue presented here or to rebut the significant conflict between the decision below and that of the Third Circuit in *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985).

To begin with, respondents do not dispute the economic impact of the exclusion at issue in this case. *See* Pet. at 5-6. Podiatrists and orthopedists compete in providing inpatient foot surgery. Forsyth Memorial is the only hospital available to petitioners in the relevant geographical market. By denying them co-admitting privileges, respondents have, over a five-year period, forced Drs. Cooper and Daniels to refer 388 of their foot surgery patients to staff physicians at the Hospital. Thus, Drs. Cooper and Daniels have lost the income associated with providing such treatment; and, equally important, their patients have lost the right to use the health care provider of their choice.

This restraint on competition and consumer choice strikes at the core of the values protected by the antitrust laws. As this Court has often reiterated, those laws "are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United*

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[1] Indeed respondents devote the majority of their brief to arguing about alleged errors and misstatements of fact in the petition. Opp. Cert. at 12-30. Petitioners disagree with all of these contentions. Yet, most of them have little bearing on whether the Court should grant *certiorari*. To the extent they may relate to that issue, petitioners discuss them in the body of this reply brief.

States v. Topco Assocs., Inc., 405 U.S. 596, 610 (1972). Since the antitrust laws embody our national policy of free enterprise and provide national standards and remedies that are unavailable under state tort or hospital laws, they represent the best means to redress anticompetitive practices in the health care industry.

The claimed "woefully" inadequate training of podiatrists (Opp. Cert. at 13-18) does not shield respondents' exclusionary conduct from antitrust scrutiny. Not only does this claim raise genuine fact issues, but it is flatly contradicted by the unanimous and unequivocal recommendations of authoritative medical and governmental bodies that podiatrists should be granted co-admitting privileges based on their individual qualifications. Pet. at 3-4. For example, the AMA formally resolved "that podiatrists as a professional group should not be denied practice privileges in hospitals" (App. E at 58a); and the North Carolina Governmental Evaluation Commission reported in 1980 that:

> The disadvantages of the blanket exclusion of podiatrists from consideration for hospital privileges are apparent. . . . [K]eeping podiatrists out of hospitals *prevents them from performing surgical procedures that they are already licensed to perform, thereby imposing an unnecessary restriction on the public's foot care options.* Patients needing foot surgery administered in a hospital setting would be forced to seek a physician for the operation. *If a podiatrist can perform surgery in his office, it is difficult to understand why he shouldn't be permitted to do the same thing in a hospital.*

App. X at 156a (emphasis added). Both the Joint Commission on Accreditation of Hospitals and the North Carolina Hospital Association recommended that podiatrists should be considered for co-admitting privileges with a

staff physician, and that, in this "dual responsibility," the M.D. would be responsible for the "general medical care" of the patient. App. F at 59a; App. G at 61a.

Consistent with these recommendations, Drs. Cooper and Daniels sought only the privilege to co-admit their surgical patients with a staff M.D. to be responsible for the medical care of the patient. Since petitioners seek only co-admission privileges, respondents' asserted patient care justification for the categorical exclusion of podiatrists is highly implausible. How can concern for treatment of "the whole person" (Opp. Cert. at 9) justify the class exclusion of podistrists when they seek only JCAH-approved co-admitting privileges?

In this setting, there can be no legitimate doubt that the decision in this case upholding summary judgment for respondents raises important national issues and creates a clear conflict among the circuits.

1. There Is a Direct Conflict Between the Decision Below and *Weiss v. York Hospital*; the Cases Are Not Distinguishable

In *Weiss*, the Third Circuit held that the York Hospital medical staff was "a combination of individual doctors and therefore . . . any action taken by the medical staff satisfies the 'contract, combination or conspiracy' requirement of Section 1." 745 F.2d at 814. This holding, as we have shown (Pet. at 17-25), provides a sound basis for applying the Sherman Act in the large and growing number of hospital access cases.[2] It is well-grounded in antitrust prin-

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[2] As pointed out in the Petition, between January 1980 and September 21, 1986, the federal courts had resolved 115 such cases compared to only 37 in the prior six year period. Pet. at 17, n.10. A subsequent LEXIS search on October 29, 1986 revealed that between September 30 and October 16, 1986, three additional opinions were filed in hospital privileges cases.

ciples;[3] it comports with the realities of the credentialing process at York, Forsyth Memorial and most other hospitals;[4] it contemplates a factual determination of whether the concerted denial of privileges had a valid health care justification;[5] and, finally, it is fully consistent with the Federal Trade Commission's enforcement policy in hospital access cases.[6]

We have shown that this case and *Weiss* are not distinguishable and that there is a direct and important conflict between the two cases. Pet. at 17-21. Respondents have attempted to minimize that conflict with three inapposite or false arguments: (1) "unlike *Weiss*, the medical staff of FMH is not a defendant in this litigation" (Opp. Cert. at 40); (2) unlike *Weiss*, the Forsyth Memorial Board has "the final authority and control of staff privileges . . ." (Opp. Cert. at 42); and (3) unlike the osteopaths in *Weiss*, podiatrists are not as qualified as M.D.'s (Opp. Cert. at 43).

The first argument is inapposite. The antitrust laws look to substance, not to form (*Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 763 (1984)) and allow a plaintiff to sue any one or more of the alleged co-conspirators. *See, e.g., Wilson P. Abraham Constr. Corp. v.*

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[3] *See Weiss*, 745 F.2d at 815-16; and Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981) at 6-7 ("Physician Control Statement").

[4] *See* Pet. at 14-17, 19-21; and *Weiss*, 745 F.2d at 796-99.

[5] *See Weiss*, 745 F.2d at 820-22; and Winslow, *Antitrust and Alternative Health Care Systems*, presented to the Antitrust and Health Care Sections, Minnesota State Bar Association at 15-16 (May 25, 1983).

[6] *See* Pet. at 21-25. While respondents contend that "FTC enforcement policy has nothing whatsoever to do with any issue in this case" (Opp. Cert. at 35) petitioners have shown that the lower courts' summary dismissal of the complaint is contrary to the FTC's enforcement approach in hospital access cases. Pet. at 21-25.

Texas Indus., Inc., 604 F.2d 897, 904 n.15 (5th Cir. 1979), *aff'd sub nom. Texas Indus., Inc. v. Radcliffe Materials, Inc.*, 451 U.S. 630 (1981). In the case of an unincorporated association, such as the Forsyth Memorial staff, "it is permissible to sue but one of several alleged co-conspirators." *Hennessey v. NCAA*, 564 F.2d 1136, 1147 (5th Cr. 1977). Here, the complaint named as defendants seven orthopedist-staff members, three allopathic physician staff members and the members of the Board of Trustees, alleging that they "combined and conspired to restrain trade and commerce by denying the plaintiffs hospital privileges. . . ." App. C at 19a-21a, 30a. These allegations are plainly sufficient to state a claim of conspiracy among the staff.

Respondents' second argument is false. At York Hospital, no less than at Forsyth Memorial, the hospital's governing body nominally has the final authority over staff privileges.[7] In reality, however, at both hospitals the medical staffs' "recommendations" were dispositive. *See* Pet. at 19-21. Under the Forsyth Memorial Bylaws, the medical staff physicians initially determine privilege issues, subject only to the Board's review as an "appellate body" (Pet. at 6); and the Board cannot overturn a privileges recommendation without holding a conference with staff for reconsideration (App. D, Art. V, § 2(i) at 42a-43a). Moreover, the political power of the physicians (*see* Pet. at 16-17) was repeatedly acknowledged by the Forsyth Memorial Board members. App. L at 84a-85a, 88a-90a, 95a-97a.[8]

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[7] As the Court of Appeals noted in *Weiss*, the hospital's "Board of Directors . . . held a special meeting at which presentations were made by counsel for Weiss and special counsel for the Hospital. On March 13, 1979, the Board voted to deny Weiss staff privileges." 745 F.2d at 799.

[8] For example, Mr. Armfield complained that the unanimous opposition to podiatry by "the whole staff plus the orthopaedists . . ." had placed him and other lay members "between a rock and a hard place. . . ." App. L at 84a. Similarly, Board member Dr. Shaffner argued, "If this board does not support the recommendations of the medical staff and thus directs

Respondents' third argument is equally meritless. Since this case was decided on summary judgment, there were no "findings" as to the relative competence of podiatrists and M.D.'s. *See* Opp. Cert. at 43. In fact, Drs. Cooper and Daniels unquestionably have "the highest qualifications" individually, as Board member Thomas stated (App. L at 96a); and the qualifications of podiatrists as a class for co-admitting privileges has been definitively resolved by the AMA, JCAH and others.[9]

Respondents' remaining contention—that there can be no concerted action here since "[o]f the thirty-five persons who voted not to change the Hospital Bylaws . . . only one was a physician doing foot surgery" (Opp. Cert. at 9-10)—is also unavailing. All orthopedists on staff compete with petitioners and all agreed to written Bylaws categorically excluding non-physicians from staff. (App. D, Art. III, § 1 at 37a). Staff orthopedists vowed to "fight individually and collectively to keep podiatrists off the staff" and voted "that none will supervise podiatrists in [the] hospital." App. S at 125a. All seven of the defendant orthopedist staff members actively participated in the Hospital's proceedings and opposed petitioners' applications

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the staff to amend the by-laws to accommodate podiatrists, then we will have a serious internal problem. . . . We would have said that we believe they have been incompetent or dishonest. . . . We would have lost their confidence and their cooperation and I'm sure we'll lose some members of the staff who will resign." App. L at 93a.

[9] Respondents' suggestion that the lower courts have recognized podiatry as an inferior practice to orthopedics (Opp. Cert. at 15-18) is false. The cases relied on by respondents do not support the proposition. *See, e.g.*, Whitehurst v. Boehm, 41 N.C. App. 670, 675, 255 S.E.2d 761, 766 (1979) (orthopedic surgeon unfamiliar with podiatry could not establish standard of care required of podiatrists; "While the law recognizes that there are different schools of medicine, it does not favor, or give exclusive recognition to, any particular school or system of medicine, as against the others.").

and any amendment of the Bylaws.[10] Finally, respondents' contention seriously misconstrues the governing law, since if a Sherman Act conspiracy required proof that the conspirators formally "voted" to commit the illegal act, then there would never be another Section 1 conviction.[11]

2. The Hospital Access Issue Presented Here Is Not One of "Wholly Local Concern"

Respondents make two erroneous contentions in opposition to petitioners' argument that the issue presented here is nationally significant. First, they contend that this Court may not consider the national significance of this case "since such argument does not fall within the scope of Rule 17 of the Supreme Court Rules." Opp. Cert. at 30-31. This claim, of course, ignores both Rule 17 itself ("special and important reasons"; "important question of federal law") and this Court's established practice. *See,*

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[10] *See, e.g.*, Defendants Underdal (App. J at 74a-76a); Pollock (App. J at 69a-72a); Tomberlin (6/6/82 Tr. Bd. Mtg. at 58-72; 7/9/82 Tr. Bd. Mtg. at 9-45, 47-59); Hays (6/6/82 Tr. Bd. Mtg. at 73-90); Rose (6/6/82 Tr. Bd. Mtg. at 90-92, 109; 6/9/82 Tr. Bd. Mtg. at 116-42); Bittinger (6/6/82 Tr. Bd. Mtg. at 101-102); Jennings (6/6/82 Tr. Bd. Mtg. at 115-21, 127-29; 7/9/82 Tr. Bd. Mtg. at 142-56).

[11] Respondents' reliance on Shaw v. Hosp. Auth., 614 F.2d 946 (5th Cir.), *cert. denied*, 449 U.S. 955 (1980), for their contention that the courts of appeal have routinely affirmed denial of hospital access to podiatrists under the antitrust laws, and that this Court has denied review, is misplaced. Opp. Cert. at 32-33. *Shaw* did not involve any antitrust claim. Similarly, although Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd mem.*, 752 F.2d 647 (11th Cir.), *cert. denied*, 105 S. Ct. 3504 (1985), is an antitrust action, the plaintiff had alleged a conspiracy among 17 hospitals and various orthopedists. Thus, it is quite different from a case such as this one which challenges the denial of privileges by concerted action within one hospital. Many of respondents' other cited cases were state court actions that did not involve the federal antitrust questions presented by this case. *See, e.g.*, Cameron v. New Hanover Memorial Hosp., 58 N.C. App. 414, *dis. review denied*, 307 N.C. 127 (1982); Davidson v. Youngstown Hosp. Ass'n, 10 Ohio App. 2d 246 (1969).

e.g., Rice v. Sioux City Cemetery, 349 U.S. 70, 79 (1955) ("special and important reasons").

Second, and equally misguided, is respondents' unsubstantiated assertion that hospital access by non-physician health care providers "is a local issue which has no national significance." Opp. Cert. at 30. Respondents dispute neither the reasoning nor authorities relied on by petitioners in demonstrating national significance. *Compare* Pet. at 13-17, *with* Opp. Cert. at 30-34. Further, in attempting to rebut petitioners' argument that they were the victims of a class exclusion, respondents' own contentions clearly reveal that this is a case of national significance.

Respondents emphatically claim that "The class that is excluded from privileges at FMH is not podiatrists but is everyone in the entire world who does not have the training and experience of a surgeon who is a medical doctor." Opp. Cert. at 22. Thus, according to their own explanation, respondents seek to exclude "everyone in the entire world" who is not an M.D. *That, petitioners submit, is exactly the point.* In addition to podiatrists, respondents' class exclusion would embrace osteopaths, clinical psychologists, nurse practitioners and nurse midwives. Such blanket exclusion of non-M.D. providers, as we have shown (Pet. at 14-17), seriously threatens consumer welfare.

Respondents' resolute determination to exclude *all* non-physicians under *all* circumstances, regardless of what the AMA, JCAH and others may say, except possibly in "small hospitals in rural areas where there are no qualified orthopedic surgeons or general surgeons . . ." (Opp. Cert. at 25), reveals two additional reasons why *certiorari* should be granted here:

First, it shows why the antitrust laws are needed in the hospital access setting. Neither state laws dealing with hospital access, such as that adopted in North Carolina in 1981, nor the strong recommendations of the standard-

setting agencies (*e.g.*, AMA, JCAH and NCHA) have been effective to breathe competition into the insular world of the physician-dominated hospital staff. *See* Pet. at 15-17.

Second, since this case involves the grant of summary judgment to respondents, it in effect creates the very antitrust exemption for M.D.'s which both Congress[12] and this Court[13] have recently rejected. If there can be no genuine issue of fact as to concerted action even where (a) the staff Bylaws establish such class exclusion,[14] (b) the staff effectively controls the process,[15] (c) the staff orthopedists directly compete with podiatrists,[16] (d) the staff orthopedists agreed to "fight individually and collectively to keep them off the staff"[17] and to boycott their supervision if they won access,[18] and (e) the asserted patient care excuse is highly implausible,[19] then all hospital access decisions effectively become exempt from antitrust scrutiny. This practical result also supports the exercise of this Court's discretionary review.

CONCLUSION

This Court should review this case because the legal questions it presents are critical to opening compet-

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[12] *Compare* 153 CONG. REC. H10,448, S15,706 (daily ed. Dec. 20, 1982), *with* 138 CONG. REC. H8755 (daily ed. Dec. 1, 1982) *and* S. 2499, 97th Cong., 2d Sess. (1982).

[13] Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 349 (1982).

[14] The Staff adopted written Bylaws which all parties agree expressly deny privileges to all but physicians and dentists. Pet. at 7; Opp. Cert. at 4-5.

[15] *See* Pet. at 6; and discussion *supra* at 5.

[16] Pet. at 5; App. I at 65a-68a.

[17] App. S at 125a; App. Q at 119a.

[18] App. S at 125a.

[19] Petitioners were qualified for access (Pet. at 3) and applied for the privilege to co-admit with an M.D. (Pet. at 2).

itive access to the insular health care industry whose costs now consume over 10 percent of our gross national product.[20]

Respectfully submitted,

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November 3, 1986

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[20] In 1985 health care costs reached $425 billion. U.S. Dept. of Health & Human Services, HHS News (Press Release) at 1 (July 29, 1986) (citing HEALTH CARE FINANCING REVIEW, *National Health Care Expenditures* (Fall 1986). *See* Pet. at 14.